

State of New Mexico
CHILDREN, YOUTH and FAMILIES DEPARTMENT

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**Office of Community Outreach and Behavioral Health Programs
Licensing & Certification Authority**

April 10, 2013

Gayle Nash, RN, MPH Acting, Administrator
Sequoyah Adolescent Treatment Center
3405 Pan American Freeway NE
Albuquerque, NM 87107

RE: 1. Residential Treatment Services/Psychiatric Residential Treatment Facility Investigative Findings: July 2012 – March 2013
2. Notice of Contemplated Action (NCA):
Temporary Certification
Directed Action Plan

Ms. Nash,

This report is a comprehensive compilation of the result of CYFD's investigation from July 16, 2012 through March 6, 2013 pursuant to Sec. 7.20.11.14(B) and (C) NMAC. This investigation has been based on stakeholder complaints, serious incident reports (SIRs), and CYFD/Statewide Intake (SCI) reports received by CYFD's Licensing & Certification Authority (LCA). Included herein is a summary and attachment of all investigative reports issued during the span of this investigation and also details findings from the investigation that have yet to be documented. These collective findings are the support for the proposed imposition of the issuance of a temporary certification under NMAC 7.20.11.9.B(4), and a Directed Action Plan. The complete Directed Action Plan contained in this report includes both new requirements and those that have been previously imposed by the attached reports. All corrective actions located in the directed action plan must be substantially completed prior to the issuance of a full certification. During this time LCA/CYFD will be working closely with Sequoya to assist with and insure continued compliance.

INTRODUCTION:

In July 2012, the LCA began receiving a series of CYFD/Statewide Central Intake (SCI) reports alleging an unsafe environment involving health and safety at Sequoyah ARTC. Since that time, LCA has received a number of reports of health, safety, and quality of care issues involving Sequoyah ARTC. LCA has conducted on-site investigations and off-site investigation of records and information reviews to address the concerns. LCA has also taken action to work in a collaborative manner with Sequoyah towards increased compliance with Certification Requirements:

- LCA has consulted with CYFD Child/Adolescent Psychiatrist, Dr. George Davis, regarding physician-related care delivery concerns identified during the course of LCA's investigative activities. LCA requested Dr. Davis provide technical assistance to Sequoyah ARTC and its contracted physicians with complex client case reviews. Dr. Davis' technical assistance has continued from September 2012 to March 2013. He has addressed treatment-related issues and discharge planning.
- On January 8, 2013, CYFD representatives (including LCA) met with Sequoyah ARTC and Department of Health (DOH) personnel. The DOH personnel reported, during the course of the meeting, an array of corrective actions and internal monitoring activities that had been initiated since November 2012 to bring the facility into regulatory compliance.
- On February 28, 2013, per DOH-OGC's request to CYFD-OGC, LCA provided DOH and Sequoyah ARTC staff with training on two regulatory topics: reporting requirements associated with abuse, neglect and serious incidents as well as RTC staffing ratio requirements. A detailed power point and accompanying handouts were provided to all attendees.
- On March 5, 2013, LCA and Dr. Davis facilitated training to Sequoyah ARTC staff on discharge planning processes used by JJS Case Management (CM) staff for its clients at CYFD's Youth Diagnostic & Detention Center (YDDC) and Camino Nuevo in Albuquerque. LCA provided Sequoyah ARTC staff hand-outs with the Certification regulations associated with Emergency and Non-Emergency Discharge requirements for all Certified Medicaid facilities.
- On March 6, 2013, LCA, CYFD-OGC and DRNM met to discuss the current status of corrective action initiatives being taken by Sequoyah ARTC and LCA to facilitate the facility achieving regulatory compliance. Both entities shared information regarding recent investigative findings related to client and staff safety.

LCA recognizes and is appreciative of all the effort involved in these endeavors by Sequoyah ARTC to address the health, safety and overall effectiveness of the treatment services provided to the clients at Sequoyah ARTC.

The following timeline includes a summary of activities related to concerns presented to the LCA:

August/September 2012

August 23-September 5, 2012: LCA investigated allegations (from an anonymous source) involving an array of concerns impacting the health and safety of clients at Sequoyah ARTC. LCA also performed the facility's annual Certification Survey. LCA issued an initial onsite Investigative Certification Report (August 30, 2012) and additional report of acute regulatory deficiencies with corresponding directed action requirements related to the regulatory violations thus far identified (September 5, 2012). Findings included non-compliance to regulations related to client discharges, restraints, medication, client supervision, physician-directed care, and personnel responsibility. Directed Corrective Action Plan addressed. See attached reports (exhibit #1 and #2). Additional findings not included in the attached reports are discussed below:

November 2012

November 6, 2012: LCA received two Sequoyah ARTC client-related complaints from Disability Rights NM (DRNM), one of which involved allegations that Sequoyah ARTC staff restrained a client [hereafter referred to as Client #1] to administer an intramuscular (IM) injection although the client was not a threat to self/others at the time of the physical restraint. LCA was told that this incident allegedly occurred on November 3, 2012. LCA conducted a comprehensive investigative review based upon the allegations made. Findings included non-compliance to regulations related to physical restraint and client rights. Emergency interventions did not demonstrate promotion/protection of client health and safety, use of restraint only in cases of imminent/serious physical harm, or compliance to client right to refuse medication and be free from unnecessary restraint. Results discussed below (Additional Findings section).

November 21, 2012: LCA received a DRNM referral on November 21, 2012 alleging a client [hereafter referred to as Client #2] (who reportedly had a history of multiple restraints) was placed in a mechanical restraint for over two hours. The referral expressed concern for Client #2's safety due to the mechanical restraint and continued risk. LCA conducted an investigative record review based upon allegations made in the complaint letter. While at Sequoyah ARTC on January 10, 2013, LCA issued a Certification Investigative Report to the Sequoyah ARTC Executive Director of the substantiated findings identified as a result of its investigation of the November 21, 2012 DRNM referral. The January 8, 2013 report (See attached report (exhibit #3). documented an array of violations of state and federal regulations governing the use of restraints of clients for Psychiatric Residential Treatment Facilities (PRTF) as well as detailed directed corrective action requirements. LCA described to the Sequoyah ARTC Executive Director the findings substantiated in the report, which included that Client #2 had been mechanically restrained beyond the maximum of 2 hours time allowed by regulation, which in this case was for 2 hours 25 minutes on November 10, 2012. The Sequoyah ARTC Executive Director acknowledged during this discussion that the facility had identified the same findings. See attached report exhibit #3

February/March 2013

February 19, 2013: LCA received notification from DRNM of an incident involving a client [hereafter referred to as Client #3] stabbing a nurse on February 15, 2013. The nurse had contacted State Police to file an assault complaint. LCA went onsite to Sequoyah ARTC the morning of February 20, 2013 to initiate an onsite investigation. An Investigative Onsite Report was issued the afternoon of February 20, 2013 to the Sequoyah ARTC Executive Director. This LCA Investigative Onsite Report included an array of regulatory findings and corresponding directed action requirements. See attached report (exhibit #4). Findings included non-compliance to regulations related to the lack of Serious Incident Reporting to LCA on this client-to-staff physical assault, which was documented in Client #3's record that he "*grabbed (the nurse) around the neck, turned her around and stabbed the back of (the nurse's) neck with the sharp.*" Sequoyah ARTC serious incident report policies and procedures were also found to be non-compliant with the requirements associated with required reporting to LCA.

February 21, 2013 thru March 6, 2013: LCA expanded its February 19th investigation of Sequoyah ARTC due to new allegations of understaffing of both nursing and milieu staff, which were allegedly making the facility unsafe for both staff and clients. During the course of the expanded investigation, LCA received an Investigative Report of Sequoyah ARTC that had been provided to the DOH Cabinet Secretary and DOH-OGC from DRNM. On March 6th, LCA issued its Onsite Investigative Report of findings with corresponding directed corrective action requirements to the Sequoyah ARTC Executive Director and other management staff. Findings included non-compliance to regulations related to staffing schedules, staff to client ratios, and staff training. See attached report (exhibit #5).

ADDITIONAL FINDINGS:

The following findings include non-compliance to regulations that require corrective action by Sequoyah ARTC which have not been addressed in any previously issued reports:

November 6, 2012 Investigative Records Review

Violation #1

NMAC 7.20.11(22)(C)(2): CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:
The agency maintains and follows written policy affirming that clients may refuse any treatment or medication, unless the right to refuse treatment(s) has been limited by law or court order. The agency informs the individual of the risks of such refusal. Client refusal of treatment and advisement of risks of the refusal is documented in the client's record.

NMSA 1978, §32A-6A-9 and 10(A):

§32A-6A-9, *Restraint, generally.* A child has the right to be free from the use of physical, chemical or mechanical restraint used for the convenience of a caregiver or as a substitute for a planned program for behavior support.

§32A-6A-10(A), *Physical restraint and seclusion.*

In a mental health or developmental disability treatment or habilitation setting, physical restraint and seclusion shall not be used unless such use is necessary to protect a child or another from imminent, serious physical harm or unless another less intrusive, nonphysical intervention has failed or been determined inappropriate.

On the evening of November 3, 2012, Client #1 had been documented as being verbally abusive, standing on top of a picnic table, slamming a door open and kicking a football. Imminent, serious physical risk to self or others was not documented as part of Client #1's behavior. Client #1's record documents that he was offered an oral PRN medication with the indication (by a nurse) that it could lead to an IM injection if the medication wasn't taken by mouth. The client stated that he didn't want the medication. Nursing contacted a psychiatrist informing him of staff attempting to deescalate the client. A doctor's order was obtained to restrain the resident to administer Thorazine 50mg IM. Records reviewed did not contain documentation of imminent, serious physical harm to self or others at the time nursing obtained the order for restraint. Client #1 was placed in a restraint and the Thorazine injection was administered. Emergency interventions utilized on the evening of November 3, 2012 did not demonstrate regulatory compliance to:

- Client right to refuse medication
- Client right to be free from the use of physical, chemical or mechanical restraint used for the convenience of a caregiver or as a substitute for a planned program for behavior support
- Use of restraint only in cases of imminent, serious physical harm

The Agency did not act to promote and protect the client's health, safety and welfare when staff restrained Client #1 for purposes of administering IM medication used as a chemical restraint under documented circumstances that did not represent the client's imminent risk to self or others.

August 30-September 5, 2012 LCA Investigation/Certification Survey

Violation #2

NMSA 7.20.11.22.C(3)(a): CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:
The client record contains all applicable consents for treatment, including consent for emergency medical treatment and informed consent for prescription medication.

Five of seven client records reviewed reflected medications had been frequently discontinued and/or changed rapidly. Sequoyah ARTC clients interviewed consistently reported that starting approximately the second week of July 2012, their psychiatric medications had been changed without their consent. Three of seven Sequoyah ARTC client records reviewed documented psychiatric medication changes without documented informed consent for the medication changes.

Violation #3

NMAC 7.20.11.23(D): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE: Assessments: Each client is assessed at admission and reassessed at regularly specified times to evaluate his or her response to treatment, and specifically when significant changes occur in his or her condition or diagnosis. The assessment process is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable.

One central document that contains all required assessment elements is not present in client records reviewed. Multiple assessments are conducted that do not contain all required areas of consideration.

Violation #4

NMAC 7.20.11.23(D)(1): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

D. At a minimum, the following assessments are conducted and documented:

(1) An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

Sequoyah ARTC utilizes the clinical review form provided by/to the payor as an Initial Screening. This document does not contain all the required elements for Initial Screening defined in regulation.

Violation #5

NMAC 7.20.11.23(D)(4): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

If the comprehensive assessment is completed prior to admission, it is updated at the time of admission to each certified service.

Four of seven client records reviewed contained comprehensive assessments completed prior to admission without update at the time of admission.

Violation #6

NMAC 7.20.11.23(D)(5)(a): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

(5) Assessment processes include the following:

(a) Within 30 days of admission, an educational evaluation or current, age-appropriate individualized educational plan (IEP), or documented evidence that the client is performing satisfactorily at school[.]

School performance information was not present as part of the Agency's assessment process in the client records reviewed.

Violation #7

NMAC 7.20.11.23(E)(3)(a): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

(3) Each initial and comprehensive treatment plans fulfill the following functions:

(a) involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible; reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record[.]

Initial treatment plans in six of seven client records reviewed did not document full participation of treatment team members. Documented reasons for non-participation by the client and/or family/legal guardian were not present in these six client records.

Violation #8

NMAC 7.20.11.23.E(3) (e) and (3)(g): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

(3) Each initial and comprehensive treatment plans fulfill the following functions:

(e) utilizes the client's strengths[.]

(g) documents in measurable terms the specific behavioral changes targeted, including potential high-risk behaviors; corresponding time-limited intermediate and long-range treatment goals and objectives; frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures; the staff responsible for each intervention; projected timetables for the attainment of each treatment goal; a statement of the nature of the specific problem(s) and needs of the client; and a statement and rationale for the plan for achieving treatment goals;

Six of the seven client records reviewed did not document utilization of client strengths. Five of seven records reviewed did not address specific behavioral changes targeted in measureable terms.

Violation #9

NMAC 7.20.11.23(E)(3)(j)(i)-(iii),(j)(v)-(vi): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

(3) Each initial and comprehensive treatment plans fulfill the following functions:

(j) documents a discharge plan that:

(i) requires that the client has achieved the objectives of the treatment plan;

(ii) requires that the discharge is safe and clinically appropriate for the client;

(iii) evaluates high risk behaviors or the potential for such;

(v) establishes specific criteria for discharge to a less restrictive setting; and

(vi) establishes a projected discharge date, which is updated as clinically indicated.

Five of seven client records reviewed did not document: achievement of treatment plan objectives in order for the client to be discharged, specific criteria for discharge to a less restrictive setting, or evaluation of client high risk behaviors (or the potential for such). Four of seven client records reviewed did not document that discharges would be safe and clinically appropriate for the client. Three discharge plans reviewed did not document a projected discharge date and/or the discharge dates were not updated as clinically appropriate.

Violation #10

NMAC 7.20.11.23(F)(1), (F)(1)(a-d), and (F)(1)(i): INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE

F. The treatment plan is reviewed by the treatment team at intervals not to exceed 30 days and is revised as indicated by changes in the child's behavior or situation, the child's progress, or lack thereof.

- (1) Each treatment plan review documents assessment of the following, in measurable terms:**
 - (a) progress, or lack thereof, toward each treatment goal and objective;**
 - (b) progress toward and/or identification of barriers to discharge;**
 - (c) the client's response to all interventions, including specific behavioral interventions;**
 - (d) the client's response to medications;**
 - (i) the effectiveness of behavior-management techniques used in the period under review.**

Three of the seven client records reviewed did not document Treatment Plans conducted within the 30 day timeframe. Three of seven client records reviewed did not: contain signatures indicating that the client and parents/legal guardians were present for all of the treatment plan reviews, review the progress or lack thereof toward each treatment goal and objective, or consistently identify progress toward and/or identification of barriers to discharge. Treatment plan reviews in five of seven client records reviewed did not document client's response to all interventions, including specific behavioral interventions or the client's response to medications.

Violation #11

NMAC 7.20.11.23(H)(1)(a), (2)(a): Prevention, planning, and processing of emergency discharge:

(1) The agency establishes policies and procedures for management of a child who is a danger to him/herself or others or presents a likelihood of serious harm to him/herself or others. The agency acts immediately to prevent such harm. At a minimum, the policies and procedures provide that the following be documented in the client's file:

- (a) that the agency makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge;**
- (2) In the event of a proposed emergency discharge, the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, guardian ad litem**

and department, if applicable, and provision to stop the discharge action until the parent/legal guardian, guardian ad litem and/or the department exhausts any other legal remedy they wish to pursue. The agency documents the following in the client record:

- (a) provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible;

Staff interviews and documentation review of two emergency discharges, demonstrated clients discharged due to severe dysregulation and assaultive behaviors. The emergency discharges did not document: agency effort to manage client behavior prior to the discharge or opportunity for the parent/legal guardians to participate in the discharge process.

Violation #12

NMAC 7.20.11.24(E)(J): BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES: E. The agency establishes and follows policies and procedures for the safe, effective, limited, and least restrictive use of behavior management practices. The policies and procedures include measures to ensure that treatment planning includes regular review of the necessity for, type and frequency of behavior management practiced in individual cases.

NMAC 7.20.11.24(M)(3), (M)(6)(f): BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES:

M. This sub-section (M) applies, for personal restraint, to facilities accredited by JCAHO, and to all residential treatment centers for seclusion. These entities require orders that are consistent with Department regulation, agency policy, and regulations of the centers for Medicare and Medicaid services (CMS) 42 CFR, Parts 441 and 483. These orders are issued by a restraint/seclusion clinician within one hour of initiation of personal restraint or seclusion, and include documented clinical justification for the use of personal restraint or seclusion.

- (3) The restraint/seclusion clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

- (6) Each order for personal restraint or seclusion must be documented in the client's record and will include:

- (f) the emergency safety situation that required the client to be restrained or put in seclusion;

NMSA 1978 §32A-6A-10A,10G.

10. Physical restraint and seclusion.

A. In a mental health or developmental disability treatment or habilitation setting, physical restraint and seclusion shall not be used unless such use is necessary to protect a child or another from imminent, serious physical harm or unless another less intrusive, nonphysical intervention has failed or been determined inappropriate.

The LCA observed a Sequoyah ARTC video recording of a client [hereafter Client # 4] repeatedly punching himself in the face demonstrating self-harming behaviors that did not result in a physical

restraint being utilized (as demonstrated by injuries sustained by repeatedly striking himself in the face). LCA's review of the incident video, with the Sequoyah ARTC staff in charge of restraint/seclusion training for the facility, received verification from this individual that the attending physician (present in the room) directed staff not to physically restrain Client #4.

LCA review of this video recorded incident demonstrates non-compliance with documentation of safe, effective, limited, and least restrictive use of behavior management practices in accordance to state and federal Certification regulations, as well as the NM Children's Code.

Treatment Plans reviewed did not document treatment team review for the necessity of behavior management interventions utilized. Discussion of the type of intervention utilized and frequency was not documented. This demonstrates non-compliance to the requirement for the Agency to regularly review the necessity for, type and frequency of behavior management utilized.

Physician Orders for emergency intramuscular (IM) medications did not document clinical justification for the use of medications used as a restraint (chemical restraint). This demonstrates non-compliance to emergency safety intervention documentation requirements.

Violation #12

VIOLATION OF REGULATION 7.20.11.25.D: MEDICATIONS:

D. Policies and procedures support self-administration of medications. Staff trained in these procedures provide supervision of self-administration of medications and document the time the medications are taken, the side effects observed, and client response, as well as any medications refused or held. When medications are self-administered by clients, a staff member may hold the container for the client and/or assist with opening the container, but may not place the medication in the client's hand or mouth.

Five of seven client records reviewed did not document all required elements listed above. Nursing staff members reported they needed more training in order to "feel safe" in their jobs, especially in reference to the newly implemented Quick-MAR program. Nursing staff reported the lack of training resulted in medication errors, inaccurate reporting of PRN medications, and a delay in clients receiving newly prescribed medications.

Violation #13

NMAC 7.20.11.25(I),(K): MEDICATIONS:

I. Medication monitoring may include input from various disciplines and the client and family. This information is used to maintain and improve the outcomes of medication therapy while minimizing any drug-related problems or adverse effects.

K. The physician documents in the client record the indication for, response to, and the potential and observed side effects of any prescription medication(s).

Clients and staff interviewed by LCA reported that medications had repeatedly been changed without input from the clients or various treatment team disciplines (including the client's therapists,

psychologists or social workers). Clients complained that they did not understand why their medications were changed or discontinued without their consent. Physicians were not consistently documenting the indication for, response to, or side effects of the medications as required.

Violation #14

NMAC 7.20.11.30(F)(1), (2)(a): RESIDENTIAL TREATMENT SERVICES AND GROUP HOME SERVICES:

F. Services:

- (1) Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined.
- (2) The agency provides a daily structured program that meets clients' needs as identified in the comprehensive assessment and as prescribed in the treatment plan. The following services are provided:
 - (a) individual, family, and group therapy, at the level of frequency documented in the treatment plan[.]

Three of seven client records reviewed did not consistently document a level of frequency for provision of therapy services. Treatment plans that prescribed a frequency for treatment services did not consistently reflect provision at the frequency prescribed.

GROUND FOR IMPOSITION OF SANCTIONS:

As set forth in these findings of specific violations, the Psychiatric Residential Treatment Services Program of Sequoyah Adolescent Treatment Center demonstrated noncompliance with the Certification Requirements for Child and Adolescent Mental Health Services, 7.20.11 NMAC.

The LCA has determined that these findings are sufficient grounds for sanction according to NMAC 7.20.11.11, specifically:

- | | |
|----------------|--|
| 7.20.11.11(A): | Failure to comply with any provision(s) of these Certification Requirements. |
| 7.20.11.11(I): | Presence of health and/or safety deficiencies found in current survey or on-site visit. |
| 7.20.11.11(M): | Regulatory deficiencies that jeopardize the health and/or safety of a client. |
| 7.20.11.11(N): | Numerous deficiencies that, in combination, jeopardize the health and/or safety of a client. |

SANCTIONS:

As authorized by Certification Requirements for Child and Youth Behavioral Health Services 7.20.11(12) NMAC, the LCA has determined that the following sanctions for the Accredited Residential Treatment Services program of Sequoyah Adolescent Treatment Center are appropriate:

NMAC 7.20.11.9(B)(4) 180-day TEMPORARY CERTIFICATION: Temporary certification is granted to a program currently serving clients that is found by the LCA to be in partial compliance with the certification requirements. The LCA determines the duration of temporary certification based on factors that may include severity of deficiencies and the program's history of compliance with certification requirements.

(b) The program submits an action plan for the LCA's approval within 14 days of receipt of the LCA certification report detailing its findings of deficiencies, unless otherwise specified by the LCA. At the discretion of the LCA, the program may also be required to implement directed action(s) within specified time frames. The program may be required to comply with terms of monitoring specified by the LCA during the period of temporary certification, based on a determination made by the LCA.

(e) If the program does not achieve substantial compliance with these certification requirements at the end of a temporary certification period, a sanction(s) may be imposed including non-renewal of certification.

NMAC 7.20.11.12(C): CORRECTION OF DEFICIENCIES:

When the LCA determines that deficiencies exist, the program must correct the deficiencies according to the following time frames or further sanctions may be imposed:

- (1) Health and/or safety deficiencies are corrected immediately.
- (2) Deficiencies that do not compromise health and/or safety are corrected within a period of time specified by the LCA.

As a result of findings included in this Report, Sequoyah ARTC is directed to take actions to address the following directed action plan requirements:

1. Develop a client record audit tool utilizing all violations cited in this report as audit indicators. The draft client record audit tool will be submitted to the LCA for review and approval within seven (7) business days receipt of this report.
2. Perform a 100 percent client chart audit of all current clients within 30 business days of receipt of this report. The comprehensive client chart audit will evaluate the current compliance status with each of the audit indicators included in all violations cited in this report. Sequoyah ARTC will submit to LCA a detailed report of its comprehensive client record audit findings listing each current client's initials as identifiers. The audit report will record a compliance score for each Violation Finding indicator in each client's record as compliant (C) or non-compliant (N).

3. Document monthly compliance monitoring related to all violations cited in this report (with submission of existing monthly report to LCA). After the initial comprehensive client record audit, Sequoyah ARTC will include in its monthly progress report a plan of correction initiatives that address any ongoing findings identified in the previous month's findings.
4. Develop and submit to the LCA a draft comprehensive Quality Assurance/Quality Improvement (QA/QI) Plan utilizing each defined requirement included in 7.20.11(20)(A-F) QUALITY IMPROVEMENT regulations. Specifically, the following elements will be included in the QA/QI plan:
 - A. Explicit detail addressing desired expectations and service outcomes for RTC services and a written plan to achieve them.
 - B. Establishment of a committee (or other mechanism) for the timely and regular evaluation of serious incidents, complaints, grievances, and related investigations. Committee evaluations will include identification of events, trends and patterns that may affect client health, safety, and/or treatment efficacy. Committee evaluation findings and recommendations will be documented and submitted to Sequoyah ARTC management for corrective action. Actions implemented and outcomes will be documented, and trends are analyzed over time. The agency will have a well-defined plan for correcting problems. When problems (or potential problems) are identified, Sequoyah ARTC will act as soon as possible to avoid any risks to clients by taking corrective steps that may include, but are not limited to:
 - (1) changes in policies and/or procedures;
 - (2) staffing and assignment changes;
 - (3) additional education or training for staff;
 - (4) addition or deletion of services.
 - C. Development of a system to utilize collected data regarding the outcome of activities for delivering continuously improving services.
 - D. Collection of formal and informal feedback from consumers of RTC services. Sequoyah ARTC will collect collateral source feedback, which is aggregated and used to improve management strategies and service delivery practices.
 - E. Collection and maintenance of information necessary to plan, manage, and evaluate the RTC program effectively. QA/QI outcomes will be evaluated on a quarterly basis, the results of which are used continuously to improve performance.
 - F. Implementation of a continuous quality improvement process, reviewed annually, through which Sequoyah ARTC will systematically evaluate the effectiveness of its provided RTC services by determining whether its services meet pre-determined quality improvement expectations and outcomes, and will correct any observed deficiencies identified through the quality improvement process.

In the event Sequoyah ARTC has already taken steps to address certain action plan items, LCA will accept documentation of improvements made. Feedback will be provided to Sequoyah regarding whether additional action is required. Corrections that have already been made and submitted to LCA do not require duplicative correction. Plans of correction will continue as submitted and approved.

LCA acknowledges Sequoyah ARTC's continued compliance with the following previous Directed Corrective Action Plan (DCAP) Items:

August 30, 2012 Report DCAP

1. Sequoyah ARTC will not discharge any client unless the client is in need of medical treatment such as for an injury or medical illness until further notice from the LCA.
2. Sequoyah ARTC will ensure that if current practice is dictating that only a psychiatrist may order restraint or seclusion on site then Sequoyah ARTC will have a psychiatrist physically present at the facility 24 hours per day for the period of August 30, 2012 through September 4, 2012. If Sequoyah ARTC does not provide 24 hour psychiatrist coverage, then Sequoyah ARTC will reinstitute its previous practice of allowing psychologists to order restraint and seclusion. In emergency safety situations, Sequoyah ARTC will ensure that direct care staff have the authority to act to protect any client from imminent harm to self or others. Sequoyah ARTC will submit in writing its intention related to this directed item to the LCA by 8:30 am on Friday August 31, 2012.
3. Sequoyah ARTC will complete a 100% medical records audit of each client's current medications and provide documentation of this audit to the LCA before 2:00 pm on August 31, 2012.
4. Sequoyah ARTC will provide to the LCA by 2:00 pm on August 31, 2012 a staffing schedule for all units covering the period August 30, 2012 through September 4, 2012. Included in this staffing schedule will be a designated On-Call clinician for after hours and through September 4, 2012 (through the holiday weekend).

September 5, 2012 Report DCAP

1. Sequoyah ARTC will not discharge any client unless the facility demonstrates full compliance with all regulations related to emergency and non-emergency discharges as documented in the client record according to ALL defined actions in 7.20.11(23)(G)(H)(I)
2. Sequoyah ARTC will submit to LCA revised Policies and Procedures that demonstrate step by step compliance with discharge-related Regulations in 7.20.11(23)(G)(H)(I) no later than Friday, September 14th at 12:00 noon. Policies and Procedures will define what specific facility position will be made fully responsible for ensuring full compliance for each action.
3. Sequoyah ARTC administration will convene a Multi-Disciplinary Team including the medical director, its psychiatric nurses and clinicians to develop revised and detailed Medication Monitoring and Documentation Policies and Procedures that operationalize full compliance with 7.20.11(25)(I)(K). Revised P&P's will include a staff position fully responsible for enacting and ensuring full compliance through a monthly internal, documented monitoring with immediate corrective actions if any area of non-compliance is identified.
4. Sequoyah ARTC will notify the LCA in writing regarding its policy and practice that demonstrates compliance with CFR requirements related to physician directed care. Sequoyah ARTC will notify LCA no later than September 10, 2012 at 12:00 pm who will be the designated Medical Director for Sequoyah ARTC. Sequoyah ARTC will submit to LCA

specific and detailed procedures for compliance with identifying a "treating" physician for current and future admissions.

5. Sequoyah ARTC will document the administration of IM medications used as chemical restraints as required in the CFR. Additionally Sequoyah ARTC will submit to LCA revised Policies and Procedures that demonstrate step by step compliance with Federal requirements for the use of restraint and seclusion no later than Friday, September 14th at 12:00pm. Policies and Procedures will define what specific facility position will be made responsible for ensuring full compliance for each action.
6. Sequoyah ARTC will submit to the LCA the proposed staffing schedule covering the period September 5, 2012 through September 30, 2012 for direct care staff, nursing and psychiatry. This staffing schedule will be submitted to LCA by 2:00pm on Friday September 7, 2012. Additionally on each Monday morning by 11:00 a.m., beginning September 10, 2012, Sequoyah ARTC will submit to the LCA the schedule reflecting any changes that occurred to the schedule for the previous week.
7. Sequoyah ARTC will submit to the LCA no later than September 14, 2012 at 12:00 pm a detailed work plan that addresses each of the deficiencies and directed action items identified in this Certification Report of acute findings. The work plan will define each corrective action intervention, time frame for initiation and completion and individual responsible for each.

January 8, 2013 Report DCAP

1. To ensure each treating Psychiatrist at Sequoyah ARTC is well-informed and knowledgeable regarding the state and federal regulatory requirements governing the use of restraints and seclusions of children and youth, including all restraint and seclusion Physician Order requirements, a comprehensive training curriculum will be developed, approved by LCA and then provided to the Sequoyah ARTC treating Psychiatrists within 30 calendar day's receipt of this report.

One portion of the mandatory Restraint and Seclusion training for Sequoyah ARTC's treating Psychiatrists will be documented completion of the full Restraint/Seclusion training curriculum required of all Sequoyah ARTC direct service staff. The second portion of the mandatory Restraint and Seclusion training for Sequoyah ARTC's treating Psychiatrists will include curriculum addressing the following Physician Order restraint documentation requirements related to:

- a. Clinical justification for the use of each restraint
- b. Emergency safety intervention ordered
- c. Emergency intervention length of time including maximums allowed based upon client ages
- d. Obtaining further instructions or a renewal order for restraints beyond the ordered or maximum time limit

A copy of the Psychiatrist Restraint/Seclusion training curriculum will be submitted to the LCA for review and approval prior to the actual trainings being given to all of the Sequoyah ARTC treating Psychiatrists. Upon completion of the comprehensive Psychiatrist Restraint/Seclusion trainings to all treating Psychiatrists, Sequoyah ARTC will submit to the LCA documentation demonstrating successful completion of the trainings by each Psychiatrist.

2. Documented training for each direct service staff and Psychiatrist on Sequoyah ARTC's Seclusion and Restraint policies and procedures as defined in 20-03-00 and 20-03-01 to be completed within 30 calendar days receipt of this report.
3. One designated Sequoyah ARTC staff will be identified and communicated to the LCA as its primary point of contact responsible for developing and submitting a comprehensive action plan to ensure achievement of sustained substantial compliance with all regulations governing the ordering and use of restraints and seclusions in Sequoyah ARTC.
4. As part of the Sequoyah ARTC action and monitoring plan, the designated Sequoyah ARTC staff will develop an internal audit tool for documenting monthly compliance monitoring for restraints performed during the previous month. The draft restraint audit tool will be submitted to the LCA for review and approval within seven (7) business days receipt of this investigative report. The documentation of the monthly compliance monitoring of each restraint will accompany the monthly progress report to the LCA.
5. The monthly Sequoyah ARTC restraint audit tool will include: unduplicated tracking and trending of each restraint [chemical, mechanical and physical] initiated during the previous month, grouped by individual client name. Included in the individual client restraint documentation will be the date and start and end times of each restraint; staff names involved in the restraint; the circumstances resulting in the use of restraint; strategies used by the staff, the resident, or others in attempt to prevent the need for restraint; time and date of debriefings for each client restraint; documentation of treatment plan changes made as a result of each debriefing; Physician Order compliance with each of the state and federal requirements related to restraint Physician Orders; unduplicated client or staff injuries during restraint documenting the client or staff name, date and time of injury; and documentation of law enforcement involvement associated with any restraint.
6. Upon approval of Sequoyah ARTC's Action Plan, the LCA requests a monthly progress report, due by 5pm on the last Friday of each month, to include the following information:
 - For each action plan intervention defined in the comprehensive action plan, a responsible party will be named with the individual's name, title and contact information (direct phone number and email address)
 - Status/Progress made for each corrective action intervention
 - Identified barriers/challenges to change/progress towards substantial compliance
 - Identification of necessary systems improvement to ensure substantial, sustained compliance
 - Policies, procedures and/or processes to create and maintain systems changes contributing to sustained, substantial compliance

Compliance with the above is incorporated into the required corrective action and must remain ongoing to meet the requirements of the directed action plan.

RIGHT TO HEARING:

The Agency has a right to appeal the Corrective Action items by submitting a written request for an appeal hearing within ten working days of receipt of this notice. If the Agency requests a hearing, a hearing officer will be assigned and a hearing date established. If no hearing is requested, the sanction will take effect ten working days after receipt of this notice.

The Agency may request an informal resolution conference. The purpose of the informal resolution conference is to allow an opportunity for the agency to present new evidence or arguments regarding plans to remedy deficiencies and/or discuss possible pre-hearing dispositions. The LCA has discretion to accept or reject any proposal made by the program. The informal resolution conference does not postpone any deadlines for appeal unless the LCA and the program both agree in writing.

For additional details concerning the opportunity for a full and fair review before an impartial hearing officer, please refer to the Certification Requirements for Child and Youth Behavioral Health Services, 7.20.11 [NMAC] (3/29/02).

To request an appeal hearing and/or an informal resolution conference, send/fax a timely written notice of request to:

Children, Youth and Families Department
Licensing and Certification Authority
Attn: Olivia Ridgeway, Program Manager
Fax: (505) 827-4595

The faxed request should be followed by an original signed copy mailed to:

Children, Youth and Families Department
Licensing and Certification Authority
1920 Fifth Street
Santa Fe, NM 87505
Attn: Olivia Ridgeway, Program Manager

Lastly, please note that duly appointed representatives of CYFD and the LCA may make random onsite checks to monitor Sequoyah ARTC's implementation of corrective action and compliance with Certification Requirements for Child and Youth Behavioral Health Services; and the federal Conditions of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One.

Thank you for your prompt attention to these matters.

Sincerely,



Jennifer Padgett, Deputy Cabinet Secretary
Children, Youth and Families Department

cc: Sandra Chavez, Bureau Chief, HSD
file

Sequoyah Adolescent Treatment Center

Table of Exhibits

Exhibit 1- August 2012 Licensing & Certification Authority Report issued to Sequoyah

Exhibit 2- September 2012 Licensing & Certification Authority Report issued to Sequoyah

Exhibit 3- Sequoyah Adolescent Treatment Centers Work Plan Issued to Licensing & Certification Authority September 2012

Exhibit 4- January 2013 Licensing & Certification Authority Investigative Report issued to Sequoyah

Exhibit 5- February 2013 Licensing & Certification Authority Onsite Report issued to Sequoyah

Exhibit 6- March 2013 Licensing & Certification Authority Onsite Investigative Report issued to Sequoyah

Certification Report

Name of Agency: Sequoyah Adolescent Treatment Center

Date of Survey: August 27-31, 2012

Address of Agency: 3405 W. Pan American Freeway NE Atlanta, NM 87107

Service: BMS CCSS DTS GHS TFC RUS/PRIE

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
7.20.11.23.1 (1)-(3)	① Client Discharges non-emergency discharge occurs in accordance with the client's discharge plan unless precipitated by a client's or guardian refusal to consent to further treatment.	Sequoyah ARTC will not discharge any client unless the client is in need of medical treatment such as for an injury or medical illness until further notice from the LCA.	
7.20.11.23.1 (1)-(3)	② Emergency discharge: The agency provides at a minimum procedural due process including written notice to the family/legal guardian and provision to stop the discharge action.	Sequoyah ARTC will ensure that if current practice is dictating that only a psychiatrist may order Restraint or Seclusion on site, then Sequoyah ARTC will have a psychiatrist physically present at the facility 24 hours per day for the period of August 30, 2012 through September 4, 2012. If Sequoyah ARTC does not provide 24-hour psychiatrist coverage, then Sequoyah ARTC will reinstitute its previous practice of allowing psychologists to order Restraint and Seclusion. In Emergency safety situations, Sequoyah ARTC will ensure that direct care staff have the authority to act to protect any client from imminent	
7.20.11.20.1 (1-4)	③ Restraint or Seclusion: When problems (or potential problems) are identified, the facility acts as soon as possible to avoid risks to clients by taking corrective steps.		
7.20.11.24.1 (1)-(2)	Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership are clearly defined.		
7.20.11.24.1 (3)	Restraint and seclusion... are used in Emergency circumstances to ensure the immediate physical safety of the client, other clients, staff members or others, and when less restrictive interventions have been determined to be ineffective.		

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Andrew West
Signature of Owner/Operator/Administrator
Lyette
Liaison

8/30/12
Date
8/30/12
Date

(505) 350-1399
Phone Number

Additional Report to Follow:
☒ Yes ☐ No (Circle One)

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT LICENSING AND CERTIFICATION AUTHORITY

Certification Report

Name of Agency Sequoiah Adolescent Treatment Center

Date of Survey August 27-31, 2012

Address of Agency 3405 W. Pan American Freeway NE Albuquerque, NM 87107

Service: BMS CCSS DTS GHS TFC RTG PRTE

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
7.20.11.25.A 7.20.11.25.D 7.20.11.25.H 7.20.11.25.I 7.20.11.25.K 7.20.11.22.G (1), (2)	⑬ MEDICATION ERRORS: The agency establishes and follows P-P governing the storage, handling, use, administration and disposal of all medications that are consistent with applicable laws, regulations, and accepted professional practices. ⑭ Personnel in all respects qualified to perform the functions for which they are responsible.	(CONTINUED) harm to self or others. Sequoyah ARTC will submit in writing its intention related to this Directed Item to the LCA by 8:30 a.m. on Friday August 31, 2012. Sequoyah ARTC will complete a 100% medical records audit of each client's current medications and provide documentation of this audit to the LCA before 3:00 p.m. on August 31, 2012. Sequoyah ARTC will provide to the LCA by 2:00 p.m. on August 31, 2012, a staffing schedule for all units covering the period August 30, 2012 through September 4, 2012. Included in this staffing schedule will be a designated on-call clinician for after-hours and through September 4, 2012 (through the holiday weekend).	

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Signature of Owner/Operator/Administrator [Signature]

Liaison [Signature]

Date 8/30/12

Phone Number 505-350-1399

Additional Report to Follow:
Yes ☒ No ☐ (Circle One)

Certification Report

Service: BMS CCSS DTS GHS TFC TFS RTS PRFF

the completion date directed to the Agency Liaison **

Date _____

Phone Number _____



Signature:  Liaison

Original Certificate File

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT

Certification report

CENSING AND CERTIFICATION AUTHORITY

Name of Agency Sequoiah Adolescent Treatment Center Date of Survey August 27-September 5, 2012
 Address of Agency 3405 W. Pan American Hwy NE, Auburn 97107 Service: BMS CCSS DTS GHS TFC RTS (PREF)

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
7.20.11.25A	The agency establishes and follows policies and procedures governing the storage, handling, use, administration and disposal of all medications that are consistent with applicable laws, regulations, and accepted professional practices.	SEQUOIAH ADMINISTRATION WILL CONVEY A MULTI-DISCIPLINARY TRAINING TO THE MEDICAL DIRECTOR, ITS PSYCHIATRIC NURSES, AND CLINICIANS TO DEVELOP REVISED & DETAILED POLICIES & PROCEDURES THAT OPERALIZE FULL COMPLIANCE W/ 7.20.11.25A. I.M.K. REVISED & WILL INCLUDE A DEFINED STAFF POSITION FULLY RESPONSIBLE FOR ENACTING & ENSURING FULL COMPLIANCE THROUGH MONTHLY INTERNAL, DOCUMENTED MONITORING/IMMEDIATE CORRECTIVE ACTIONS IF ANY AREA OF NON-COMPLIANCE IS IDENTIFIED.	
7.20.11.25.E	Medication monitoring may include input from various disciplines and the client and family. This information is used to maintain and improve the outcomes of medication therapy while minimizing any drug-related problems or adverse effects.		
7.20.11.25.K	The physician documents in the client record the indication for, response to and the potential and observed side effects of any prescription medication(s).		

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Anita Westberg Date 9/5/12
 Signature of Owner/Operator/Administrator

Lynette G. G. Date 9/5/12
 Signature of Liaison

Phone Number

Additional Report to Follow:
 Yes ☒ No ☐ (Circle One)

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT LICENSING AND CERTIFICATION AUTHORITY

Certification Report

Name of Agency Sequoyah Adolescent Treatment Center

Date of Survey August 27-September 5, 2012

Address of Agency 3405 W-Pan American Freeway NE Apt 3408 87107

Service: BMS CCSS DTS GHS TFC RTS/PTF

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
CFR 483.354	A Psychiatric Residential Treatment facility (PRTF) is a separate, stand alone entity providing a range of Comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician	1. Sequoyah APTE will notify the LCA in writing regarding its policy and practice that demonstrates compliance with CFR requirements related to Physician Directed Care. 2. Sequoyah APTE will notify LCA no later than September 10, 2012 at 12:00 pm who will be the designated Medical Director for Sequoyah APTE. 3. Sequoyah APTE will submit to LCA specific and detailed procedures for compliance with identifying a "Treating" physician for current and future admissions	9/10/12
CFR 483.358(b)	If the residents treatment team physician is available, he or she can order restraint or seclusion. The "treating" physician is the physician who is responsible for the management and care of the resident.		9/10/12

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Antia Westbrook
Signature of Owner/Operator/Administrator
Lyndee P. R.
Liaison

9/5/12
Date

9/5/12
Date

Phone Number

Additional Report to Follow:
☒ Yes ☐ No (Circle One)

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT LICENSING AND CERTIFICATION AUTHORITY

Certification Report

Name of Agency Sequoiah Adolescent Treatment Center Date of Survey August 27 September 5, 2012
 Address of Agency 3405 W. Pan American Freeway Ste. A BURBANK 9107 Service: BMS CCSS DTS GHS TFC RTS PRTE

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
CFR: 483.358(g) 483.358(g)(1) 483.358(g)(2) 483.358(g)(3) 483.358(h)	Each order for restraint and seclusion must include: - The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint and seclusion; - The date and time the order was obtained; - The emergency safety intervention ordered including the length of time for which the physician or other licensed facility practitioner permitted by the state and the facility to order restraint or seclusion. Staff must document the intervention in the residents record. The documentation must be completed by the end of the shift in which the intervention occurs. Documentation includes: - The emergency safety situation that required the resident to be restrained	Sequoiah ARTC will document the administration of IM medications used as chemical restraints as required in the CFR. Additionally, ARTC will submit to LCA revised P+P's that demonstrate step by step compliance w/ Federal requirements for the use of restraint and seclusion. No later than Friday September 14th at 12:00 p.m. P+P's will define what specific facility position will be made responsible for ensuring full compliance for each action.	

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Signature of Owner/Operator/Administrator [Signature] Date 9/5/12
 Signature of Liaison [Signature] Date 9/5/12
 Additional Report to Follow: Yes (Circle One)
 Phone Number _____

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT LICENSING AND CERTIFICATION AUTHORITY

Certification Report

Name of Agency Sequoiah Adolescent Treatment Center Date of Survey August 27-SEPTEMBER 5, 2012
 Address of Agency 3405 W. PAN AMERICAN Fwy NE, ALBUQ NM 87107 Service: BMS CCSS DTS GHS TFC RFS PRTE

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
7.20.11.16 A	Personnel are trained, supervised and in all respects qualified to perform the functions for which they are responsible.	Sequoiah ATRC will submit to the LCA the proposed staffing schedule covering the period September 5, 2012 Through September 30, 2012 for direct care staff, nursing and psychiatry. This staffing schedule will be submitted to LCA by 2:00pm on Friday September 7, 2012. Additionally on each Monday morning by 11:00 AM, beginning September 10, 2012, Sequoiah ATRC will submit to the LCA, the schedule reflecting any changes that occurred to the schedule for the previous week.	9/7/12
7.20.11.30 F(1)	The agency provides services, care and supervision at all times, including: Maintenance of a staff-to-client ratio appropriate to the level of care and needs of the client.		9/10/12

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Antia Wilson 9/5/12
 Signature of Owner/Operator/Administrator Date
Isabelle Garcia 9/5/12
 Liaison Date
 Phone Number _____

Additional Report to Follow:
☒ Yes ☐ No (Circle One)

CHILDREN, YOUTH, AND FAMILIES DEPARTMENT LICENSING AND CERTIFICATION AUTHORITY

Certification Report

Name of Agency Sequoia Adolescent Treatment Center Date of Survey August 27, 2012 - September 5, 2012
 Address of Agency 3405 W. Pan American Freeway, Alhambra, CA 91807 Service: BMS CCSS DTS GHS TFC RTSPRT

REFERENCE TO REGULATIONS	DEFICIENCY	DIRECTED ACTION	EXPECTED DATE OF COMPLETION
NMSA	7.20.11.16 A ✓ 7.20.11.23.H.(2)(a)(b) ✓ 7.20.11.23.H ✓ 7.20.11.25.A ✓ 7.20.11.25.F ✓ 7.20.11.25.K ✓ 7.20.11.30.F(b) ✓	⑦ Sequoia ATEC will submit to the LCA no later than September 14, 2012 at 12:00 p.m. a detailed work plan that addresses each of the deficiencies and Directed Action Items identified in this Certification Report of Acute Findings. The work plan will define each corrective action intervention, time frame for initiation and completion, and individual responsible for each.	9/14/12
CFR	483.358(g) 483.358(g)(1) 483.358(g)(2) 483.358(g)(3) 483.358(h) 483.354 483.358(b)		

Verification of correction needs to be submitted on or before the completion date directed to the Agency Liaison

Signature of Owner/Operator/Administrator Andrea Westwood Date 9/5/12
 Signature of Liaison Lyndee J. [Signature] Date 9/5/12
 Phone Number _____

Additional Report to Follow:
☒ Yes ☐ No (Circle One)

Received by
SEPT 14 2012
Hand Delivered

Sequoyah Adolescent Treatment Center
Work Plan
September 14, 2012

ISSUE IDENTIFIED	CORRECTIVE ACTION	DATE	RESPONSIBLE PARTY
Client discharges must be in full compliance with all regulations: Emergency Discharges	1. No discharge will be made without authorization by the clinical director and administrator. 2. A flowchart will be used to assure staff understanding and compliance with actions identified in 7.20.11.23.H.	Immediate September 14, 2012	Administrator Clinical Director Administrator, Administrator-on-Call. Clinical Director
Client discharges must be in full compliance with all regulations: Non-Emergency	3. Policy & procedures will be revised to assure step-by-step compliance with all regulations. 4. A flowchart will be used to assure staff understanding and compliance with actions identified in 7.20.11.23.H.	September 14, 2012 September 14, 2012	Discharge Planner Administrator Clinical Director
Agency must establish and follow policies governing storage,	5. Policy & procedures will be revised to assure step-by-step compliance with all regulations. 6. Current policy & procedure will be	September 14, 2012	Administrator, DON

handling, use, administration and disposal of all medications.	reviewed and revised as necessary to conform to regulations.		Clinical Director
Medication monitoring information is used to maintain and improve outcomes of medication therapy while minimizing any drug-related problems or adverse effects. Input may include various disciplines, the client and family.	7. Treatment team minutes will be revised to include resident medication changes. Minutes will be reviewed to determine if adequate for compliance.	September 21, 2012	Clinical Director
	8. Structure of team meetings will be assessed to better allow for input/feedback of residents and custodians.	September 17, 2012	Clinical Director
	9. Based on feedback, procedures for team meetings will change.	September 28, 2012	Clinical Director
Physician documents indications, response and potential and observed side effects of any prescription medication(s).	10. Physicians will dictate monthly a medication management note which discusses items required.	September 21, 2012	Medical Director
A multi-disciplinary team will develop revised and detailed policies and procedures which operationalize full compliance.	11. Committee will meet to assess current P&Ps and recommend changes.	September 11, 2012	Clinical Director
	12. Drafts of new P&Ps will be reviewed, edited and authorized.	September 21, 2012	Administrator
Policy & practice regarding physician-directed care will be sent to LCA.	13. A letter will be sent to LCA stating how assignment of physicians will occur.	September 10, 2012	Administrator
	14. A letter notifying the LCA of individual designated	September 10, 2012	Administrator

Facility must identify the treatment team physician.	as the Medical Director will be sent.	September 17, 2012	Administrator
	15. Facility will submit to LCA detailed procedures for compliance with identifying the "treating" physician for current and future admissions.		
Compliance with seclusion and restraint regulations	16. All IM medications used as chemical restraints will be documented as chemical restraints and all policies and procedures will be followed.	September 14, 2012	Administrator, Clinical Director, Medical Director
	17. Revised policies and procedures demonstrating step-by-step compliances will be sent by 9/14/2012 at noon. Accountability by position will be identified.	September 14, 2012	Clinical Director, Administrator
Personnel are trained, supervised and qualified to perform functions.	18. Schedules will be submitted to licensing weekly for nursing, direct care, and psychiatry.	September 7, 2012	HR Director
Maintenance of staff-to-client ratios are maintained per level of care and acuity.	19. Changes will be submitted every Monday for the previous week.	September 10, 2012 and weekly	HR Director
Completion of Work Plan	20. All corrective actions with timeframes will be identified.	September 14, 2012	Administrator

9 1 2 3 4 5

NUMBER: 15-06-00

EFFECTIVE: 12/20/92

REVISED: 9/16/98 - 01/06/99 - 01/03/00 -

01/31/01 - 01/02 - 06/29/04 - 06/05/05 -

06/05/06 - 6/12/09 - 9/6/11, 6/12; 9/12

SUBJECT: Discharge/Aftercare

I. PROCEDURE

Preliminary discharge planning begins at admission when the treatment team identifies and recommends a preliminary discharge plan. Discharge occurs when the resident has completed the discharge criteria established in the treatment plan and it is determined by the treatment team that he is ready to move to a lower level of care, unless precipitated by a resident's or guardian's refusal to consent to further treatment, or other unforeseen circumstances.

- A. The discharge planner is responsible to assure the interdisciplinary team does the following:
- Evaluated the appropriateness of release of the client to the parent/legal guardian;
 - Provides that any discharge of the resident occurs in a manner that provides for a safe and orderly transition;
 - Provides for adequate pre-discharge notice, including specific reason for discharge.
- B. The legal custodian participates in the decision and makes recommendations. Services are identified which are appropriate to these needs. Should the legal custodian not be available or is unwilling to participate, the discharge planner will contact either child protective services or adult protective services to assist in the discharge process.

COPIES OF RECORDS

After a valid release of information, the following documents will be sent to the agency where the resident is being referred, as well as a cover letter indicating why the resident is being discharged.

- Most recent concurrent review
- Psychosocial Assessment
- Psychological Testing (if done)
- Immunization record
- Psychiatric Assessment
- Educational records to include any testing, IEP, etc

A resident is not discharged until all arrangements for placement, follow up, etc., has been finalized and final approval has been received from the managed care organization or responsible insurance provider.

Emergency Discharges:

In the event of a proposed emergency discharge, the family, legal guardian, guardian ad litem, and CYFD or APS (if applicable) will be notified in writing of the proposed discharge and afforded procedural due process. Notification of due process will include the provision to stop the discharge action until the parent, legal guardian, guardian ad

litem or CYFD exhausts any other legal remedies they wish to pursue. At a minimum the clinician of record will document the following in the resident's record:

- Provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible; and
- Arrangement for a conference to be held including all interested persons or parties to discuss the proposed discharge, whenever possible, and the results of that meeting.

An emergency discharge will not occur until a safe and orderly plan has been developed. If the family is unavailable or unwilling to take physical custody of the resident, a referral will be made to SCI (Statewide Central Intake). Emergency discharges will not occur without authorization by the clinical director or the administrator/administrator-on-call.

Immediate discharge as a result of legal action, for example, pick-up for a warrant, return to incarceration due to non-amenability, violation of probation is not considered an emergency discharge initiated by the facility.

- C. Prior to the discharge date, the milieu staff will conduct an inventory of the resident's belongings and the finance office will be notified and arrangements made for the resident to receive any monies deposited.

- D. DISCHARGE ORDER:
On the day of discharge an order will be written by a licensed psychologist or a physician.

- E. DISCHARGE INSTRUCTIONS

The treatment team physician, or physician on duty if the treatment team physician is unavailable, will write discharge orders for medications.

The therapist will initiate the discharge instruction form. The resident/receiving person will be provided a copy of the discharge instructions and a copy is placed in the medical record. Discharge instructions contain specific information concerning the individual or program responsible for providing the follow-on care as well as the dates and times of the scheduled appointments. The Nursing Department will provide medication information and instructions per the physician's written discharge instructions.

- F. The Managed Care Organization Discharge Notification Form will be completed by the therapist within 72 hours of discharge.

- G. DISCHARGE SUMMARY

1. A discharge summary will be written and placed in the resident's record within fifteen days following the resident's discharge.
2. The discharge summary will include at least the following information:
 - a. Reason for treatment
 - b. Significant findings
 - c. Target behaviors addressed and progress attained

- d. DSM-IV diagnoses
- e. Discharge recommendations including safety concerns
- f. Description of successful and un-successful interventions
- g. Medications at discharge

H. FOLLOW UP

A follow-up will be conducted at thirty days, ninety days, and six months. If there is concern about the discharge plan, contact will be made sooner. The resident, and when appropriate, his family will be contacted to determine the efficacy of the discharge plan by evaluating and obtaining information from the resident, his family/custodian and the accepting agency or program. Information obtained from the follow up questionnaires will be incorporated into the Performance Improvement program to evaluate and improve the program.

Date

Anita Westbrook, Administrator

#2

Emergency Discharge

In the event that it has been determined that we are unable to manage a residents safety within the facility and all appropriate efforts have been made to maintain the safety, an emergency discharge may be proposed

Administrator/On Call and Clinical Director must be notified and approve of proposed discharge

The family, legal guardian, GAL, and department (CYFD), if applicable, will be notified in writing of the proposed discharge

In the event an of the above parties disagree with the proposed discharge, then the above parties will be involved in the discharge planning and a care conference will be scheduled as soon possible a decision about discharge will be made at the time

A safe and orderly plan will be developed, if the family or guardian does not agree and will not take custody of the resident, StateWide Central Intake (SCI) will be notified

SATC will not discharge until a safe and orderly plan has been determined

When a safe and orderly plan has been determined the nursing department will be notified and will provide medication information and instructions per physicians written discharge orders

Assigned therapist will provide discharge instructions including, legal guardian, discharge placement, any appointment, dates and assure all personal items have been returned to resident

Millieu staff will conduct inventory of residents belongings and monies are accounted for

On the day of discharge an order will be written by a licensed psychologist or a physician

NON-EMERGENCY (PLANNED) DISCHARGES

Discharge occurs when the resident has completed the discharge criteria established in the treatment plan

Assigned therapist will initiate the discharge instruction once the treatment team has reviewed and agreed that the resident has met all treatment goals necessary for discharge at least 3 weeks prior to projected discharge date.

A core Service Agency (CSA) will be notified at that time

Prior to discharge (at least 3 weeks) SATC Treatment Team will:

- 1) Evaluate the appropriateness of placement of the resident to the parent/legal guardian/lower level of care/JJS

Provide a discharge that occurs in manner that is a safe and orderly transition which will include; CSA notification, psychiatric, primary care, individual/family therapy and other identified services.

In the event that a resident is being discharged to a lower level of care (TFC..) The following documents will be sent to the agency where the resident is being referred:

- 1) A cover letter
- 2) Most recent concurrent review
- 3) Psychological Assessment
- 4) Psychological testing (if available)
- 5) Psychiatric Assessment
- 6) Educational Records

When aftercare is indicated at the time of the discharge SATC involves the resident and other involved participants in arranging appointments, obtaining medication, transportation and meeting other identified needs as documented in the treatment/ discharge plan.

Nursing Department will be notified as soon as discharge plans are established; nursing will assure the resident seen by SATC pediatrician for any medical issues (i.e. allergies, acne etc.). Nursing will also arrange that the resident be discharged with all medications, and a prescription for at least a 30 day supply of medications, depending on insurance. They will also prepare and review with resident and guardian a copy that list medications and discharge instruction per the physician.

A resident is not discharged until all arrangements for placement follow up, etc. has been finalized and final approval has been received from the managed care organization or responsible provider.

On the day of discharge an order will be written by a licensed psychologist

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NUMBER: 24-01-00
EFFECTIVE DATE: 12/20/92
REVISED: 06/10/98, 11/98, 11/00
REVIEWED: 11/03 - 09/23/04, 1/25/07,
04/28/2009, 9/11, 9/12
SUBJECT: Pharmaceutical Services

I. **POLICY**

Sequoyah will follow current policies and procedures established by Pharmacare, its contracted vendor. These policies will be reviewed annually by the Director of Nursing.

II. **PROCEDURE:**

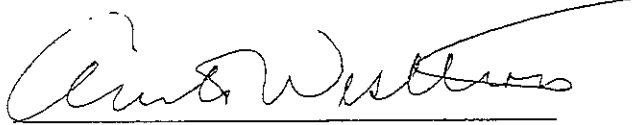
The pharmacy services, including pharmacy and therapeutics review, will be organized, directed, and integrated with the total health care delivery system through a contractual agreement with a pharmacy and a consulting pharmacist.

Sequoyah will comply with internal policies and procedures as well as those developed by the contracted pharmacy (Pharmacare Health Services) related to the total acquisition, stock, maintenance, and distribution to assure safe and secure storage, safe handling, and security of all pharmaceuticals.

Date

9/13/12

Anita Westbrook, Administrator



#6

NUMBER: 24-01-04
EFFECTIVE: 12-20-92
REVISED: 8/98 – 11/98 – 11/00-
01/09-4/09 - 9/11, 9/12
REVIEWED: 11/03 – 9/23/04
SUBJECT: Medication Administration
Record (MAR)

I. POLICY

The Electronic Medication Administration Record “QuickMAR” will be provided by the current contracted pharmacy and utilized by the nursing department to document all medication administrations.

II. PROCEDURE

1. The medication administration record will be stored in an electronic version (known as QuickMAR) provided by the contract pharmacy.
2. All medications given to residents will be recorded by the Registered Nurse who administers the medications.
3. The ROUTINE/SCHEDULED ELECTRONIC MAR provided by the contract pharmacy will be used to record all maintenance medication.
4. The PRN/EMERGENCY ELECTRONIC MAR provided by the contract pharmacy will be used to record medication given on an as-needed (PRN) or emergency basis to record the rationale and effectiveness of a PRN/Emergency medication.
5. Medications will be signed off on the MAR, by the medication nurse, as the medications are poured. If a medication is refused, the nurse will circle the entry on the MAR and write a non-administration note on the back of the MAR form.
6. All MARs will be reviewed quarterly by the consultant pharmacist.
7. After review, routine and PRN/Emergency MARs will become part of the resident's permanent medical record.
8. A MEDICATION VARIATION/ERROR REPORT will be used to record any variation of the original medication order which includes: incorrect administration/non-administration, or any incident, discovery, or situation.
9. Cross reference additions of newly ordered or changed medications to Policy 24-01-16 Medication Administration.
10. Cross reference the QuickMAR University module for procedures and training regarding QuickMar.
11. Procedures for changing an instance of medication pass documentation:

- 1) Go to the specific resident as if you were going to pass medications to him.
- 2) Click on the med pass where the specific medication is listed that you would like to change the administration information.
- 3) When you see the medication listed, click on the "history" button.
- 4) You will see all the times the medication was administered.
- 5) Select the date/time you want to change.
- 6) Click on view/edit.
- 7) Type in the "reason for change"
- 8) Then click on view/edit again.
- 9) Then click on "change".
- 10) Select the time/date you wish to change.
- 11) Also make sure to change the name to your name as the "caregiver".
- 12) Enter the "exception" and the "reason for change".
- 13) Then click save.
- 14) Your administration documentation has now been updated.

9/13/12
Date

Anita Westbrook
Anita Westbrook, Administrator